FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Health Insurance Application for Pregnant Woman

A Special Medicaid Program

Office Date Received Stamp:

Name: First | M.I. | Last | Maiden Name | Alias | Area Code ( ) Phone Number

Residence: Number | Street | Apt. No. | City | County | State | ZIP

Mailing Address (Required if different from above):

If no home phone, number where you can be reached ( )

Please answer the following questions:

1. Who in your home is pregnant? _____ **2.** Does she have Medicaid? ☐ Yes ☐ No

3. Has a Healthy Start Screening been done? ☐ Yes ☐ No **If no, ask your doctor for one.** **4.** Estimated Delivery Date: _____

5. List all of the people who live in your home (write your name first):

First M. I. Last	Social Security Number	Date of Birth	Race	Sex	Relationship To Pregnant Woman	US Citizen? Yes	US Citizen? No	If no, give INS ID Number**	Date of Entry	Applied for Medicaid? Yes	Applied for Medicaid? No
					(Self)						

**** Only required for the pregnant woman.**

6. Does the father of the unborn child live in the home? ☐ Yes ☐ No If yes, please list his name: _____

7. If the pregnant woman is under the age of 21, are her parents in the home? ☐ Yes ☐ No

8. Income: Complete the following information on anyone in the home who gets money from any source (include your parents if you are under age 21):

Name of Person Receiving Income	Income Source	Gross Income (Before Deductions)	How Often Are You Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			**Child Care Costs for Job:**
	Contributions from Others			Paid by:
	Unemployment Benefits			Paid to:
	Social Security/SSI			Child(ren) paid for:
	Other Income – List Type			Amt. Paid: $ How often:

9. Does the pregnant woman have health insurance? ☐ Yes ☐ No. If yes, give the name of the insurance company: _____

10. Are there any unpaid medical bills for the pregnant woman for the last three months? ☐ Yes ☐ No. If yes, what months: _____

PLEASE NOTE: You are required to provide proof of your pregnancy. To ensure quick processing of your application, attach proof from a qualified health professional.

CERTIFICATION AND AUTHORIZATION: I certify that the information provided on this application is true and correct to the best of my knowledge. I understand that the information provided shall be kept confidential in accordance with Florida and federal law. I authorize the release of financial and medical information for the purpose of determining eligibility, and I authorize the Medicaid program or its agents to contact me concerning my participation in prenatal care and delivery programs. I understand that information I have provided will be subject to verification, which may include computer file matching and that I may be requested to provide additional information. I have read and understand my rights and responsibilities as they apply to the Medicaid program.

Signature of Applicant: _____ Date: _____

Income Limits for Medicaid Assistance for Pregnant Women

If your household income is less than 185% of the federal poverty level, you may be eligible for Medicaid assistance. To decide if you qualify, we look at your household's gross income and the number of people in your home (including the unborn child). We allow a standard deduction and certain costs related to your work as expenses.

What You May Need:

1. Proof of citizenship/legal alien status
2. Proof of residency
3. Proof of other health insurance(s)
4. Proof of gross income of all household members
5. Proof of Social Security Number(s)
6. Proof of expected date of delivery
7. Proof of number of babies expected

Reporting Changes

You are responsible to report changes in your household's situation immediately, but no later than 10 days after you know about them. If you do not tell us this information on purpose, so you can qualify for or get more medical assistance than you were eligible for, you could be fined, put in prison, or both.

Your Application Rights

You have a right to:

1. Apply and have us see if you are eligible
2. Get Medicaid assistance once you meet all requirements
3. Help us see if you are eligible by giving us the facts we need; and by getting or allowing us to get information or forms we need from others.
4. Apply on the same day you contact the office about the Medicaid program.
5. Have us see if you are eligible without discrimination due to your age, color, handicap, marital status, national origin, political belief, race or sex.

What You are Responsible to Do

You must do the following:

1. Give us the full and correct information we need about everyone in your home when you first apply, and at interviews that follow.
2. Tell us of changes as stated above, such as: if you change your address, leave the state, or if someone moves in or out.
3. Report the change within 10 days of when it happens or you first learn about it.
4. You must **not** take part in any misuse of your medical assistance.

Your Hearing Rights:

You can ask your worker and the office supervisor to review any decision on your case. If you do not agree with the results of that review, you can ask verbally or in writing for a hearing before a State Hearings Officer. You must ask for a hearing within 90 days of the date the action you disagree with was taken. At the hearing, you may represent yourself, or be represented by your Authorized Representative, a friend, relative, lawyer, or someone else that you choose. The Hearings Officer will decide if the decision we made was correct according to law. If the Hearings Officer decides we were correct, you might have to repay any medical assistance you got for which you did not qualify.

ATTENTION APPLICANT: Tear off this sheet before mailing or returning your application.

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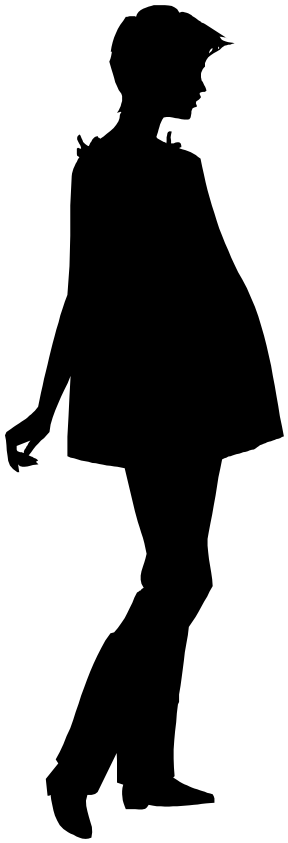

If you are pregnant, you may qualify for this special health insurance program. To see if you are eligible, check the income guidelines on the table. You can apply for this program if your family meets these guidelines, ***even if you or other family members are employed***.

To apply 1) complete this simple application, 2) attach proof of your pregnancy from a health care provider, 3) stamp and 4) mail. ***A program representative may contact you by phone to check your information***.

Once you are enrolled, the program will cover ***medical care and hospitalization*** during your pregnancy. It may also cover health care bills you received up to three months before your enrollment. There is no cost for this coverage. Your baby may also be eligible for free insurance after he or she is born.

Early and regular prenatal care can help you have a healthy baby. Visit your doctor, midwife or clinic as soon as you think that you might be pregnant. This insurance can help you pay for this important care.

If you have questions about this program or need help in filling out this application, call your local DCF office. If you need help in finding care, call 1-800-451-2229.

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MONTHLY INCOME GUIDELINES

(Effective April 2002)

HOUSEHOLD SIZE (Include Your Unborn Child)	INCOME
1	$1366
2	$1841
3	$2316
4	$2791
5	$3266
6	$3741
7	$4215
8	$4690
9	$5165
10	$5640
11	$6115
12	$6590

If your household contains more than 12 people, add $475 for each additional person.

Important Information about Medicaid

This Medicaid form is only for pregnant women. The Department of Children and Families will tell you if you qualify for Medicaid. The family size and income you list on your application is used for this. Your rights and responsibilities are:

- **If you are not found eligible for this program, you may apply at your local Department of Children and Families office for other medical programs.**
- **You agree to give the medical and financial information asked for on this form. You may be asked for proof or for more information.**
- **By federal law, you must give us your social security number. You do not have to give us social security numbers of others in your home. If you do provide us with their social security numbers, this information will be used to verify income. If the social security numbers of others is not on the application, you may need to provide proof of their income.**
- **We may check all information on your request. This includes using computer matches. We are required by state and federal law to keep your information private.**
- **You must immediately, but no later than 10 days, tell us of any changes in income or family size.**
- **Your age, color, creed, disability, marital status, national origin, race, sex, religious or political beliefs will not affect your request or service.**
- **You have the right to appeal any decision made. The Department of Children and Families or the Agency for Health Care Administration can tell you about the appeal process.**
- **Under penalty of perjury, you agree that what you wrote on this form is true, as best you know.**
- **If you misrepresent the truth on purpose, or help someone else to misrepresent the truth on purpose, you commit a crime that can be punished under federal or state law or both. If you get medical assistance for which you do not qualify, you may have to repay the cash value of that assistance. You may also be subject to other civil penalties.**

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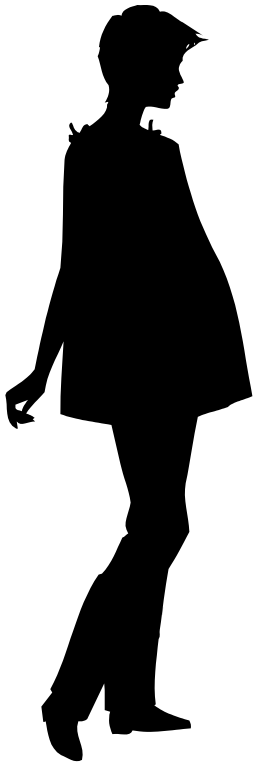

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For information or help in filling out this application call your local DCF office